REDACTED

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
GLENN CUNNINGHAM, M.D.	)	**No: 09-96-65983**
Certificate # C 38701	)	
Respondent.	)	

DECISION AND ORDER

The attached Proposed Decision is hereby adopted as the Decision and Order of the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective on March 12, 1999 at 5:00pm.

DATED February 11, 1999.

DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA

IRA LUBELL, M.D., PRESIDENT
Division of Medical Quality

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	No. 09-96-65983
	)	
GLENN D. CUNNINGHAM, M.D. 375 Via Las Palmas Palm Springs, California 92262	)	OAH No. L-1997120372
	)	
Physician's and Surgeon's Certificate No. C 38701	)	
	)	
Respondent.	)	
	)	

PROPOSED DECISION

On November 3, 4, and 5, 1998, in Riverside, California, Alan S. Meth, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter.

Michael P. Sipe, Deputy Attorney General, represented complainant.

Mark S. Rader, Attorney At Law, represented respondent.

Evidence was received, the record was closed, and the matter was submitted on November 5, 1998.

FACTUAL FINDINGS

1. Ron Joseph, Executive Director of the Medical Board of California (Board), filed Accusation No. 09-96-65983 on November 25, 1997, in his official capacity. Respondent filed a timely Notice of Defense dated December 3, 1997. On October 6, 1998, complainant filed a First Supplemental Accusation.

2. On June 25, 1979, the Board issued Physician's and Surgeon's Certificate No. C 38701 to respondent, and at all relevant times, the certificate was in full force and effect.

3. In this proceeding, complainant bears the burden of establishing the charges by clear and convincing evidence to a reasonable certainty. Ettinger v. Board of Medical Quality Assurance (1982) 135 Cal.App.3d 853. This requires the evidence be "of such convincing force that it demonstrates, in contrast to the opposing evidence, a high probability of the truth" of the charges (BAJI 2.62), and to be "so clear as to leave no substantial doubt." In re Angelia P. (1981) 28 Cal.3d 908, 919; In re David C. (1984) 152 Cal.App.3d 1189, 1208. If the totality of the evidence serves only to raise concern, suspicion, conjecture or speculation, the standard is not met.

4. In January, 1995, V[redacted] T. was living with her daughter, V[redacted] C[redacted] E[redacted], in Yucca Valley, California. She was 87 years old and had significant medical problems. On January 17, 1995, she was struck by a car driven by E[redacted], fell, and suffered fractures of the right hip and the distal left femur. She was taken to High Desert Hospital and then to Desert Hospital in Palm Springs for orthopedic evaluation and treatment. Respondent examined her on January 18 and diagnosed an intertrochanteric fracture of the right hip, displaced, and a fracture of the distal left femur, displaced. He planned an open reduction and internal fixation of the right hip and distal left fracture (hereafter, "ORIF") and advised the patient of the risks, benefits, expectations, and alternatives. She agreed to have respondent perform the surgery.

Respondent performed the surgery on January 18. In connection with the right hip fracture, respondent inserted a screw and a four-hole side plate to align the several pieces of bone of the femur. V[redacted] T. remained in the hospital until January 23, 1995, when she was transferred to the skilled nursing facility of Desert Hospital. Respondent saw her often while she was in the hospital, but the records do not reflect any visits while she was in the nursing home. She was discharged to her home on February 17, 1995.

V[redacted] T.'s first post-operative visit to respondent's office was on March 6, 1995. Respondent performed a physical examination and asked her how she felt. He charted increased range of motion in her right hip and the x-ray was good. His plan was for physical therapy of the right hip and strengthening. He expected her to return in four weeks. He did not record any information about any complaint of pain.

An x-ray report of that date noted a comminuted intertrochanteric fracture of the right hip with internal fixation.

V[redacted] T. returned to respondent's office on March 28, 1995, with a complaint of right hip discomfort. He recorded his range of motion findings which were virtually normal for a woman of V[redacted] T.'s age. He noted there was no erythema (redness) or swelling. He noted the x-ray indicated the screw was doing what it was supposed to do. Respondent's chart does not indicate he wrote any prescriptions. The x-ray report indicated a healing fracture.

V[redacted] T.'s next visit to respondent's office was on April 3, 1995. Respondent noted she was now 2 1/2 months post ORIF. His plan was for her to continue non-weight bearing and to use a walker. Nothing is recorded in respondent's chart regarding pain or medications. The x-ray report indicates no significant alteration of the fixation device.

On April 11, 1995, V[redacted] T. returned to respondent's office. The chart entry for that date appears to indicate the patient told him she had experienced erythema for three days. Respondent charted slight erythema at the proximal part of the wound of the right hip. He diagnosed a "possible superficial infection" and prescribed cipro, an antibiotic. His plan was for her to return in one week and he would check an x-ray. There was no x-ray available on April 11.

A note appears in respondent's chart which reads as follows:

> "4-14-95
>
> "C J Shepard HHC
>
> "Re: [V[redacted] T.]
> "ORIF R Hip
> ...
>
> "Wound burst this AM oozing pus & some blood. Able to get Q-tip down 3.5 cm. She will treat over weekend [with] Betadine, pack [with] iodoform gauze and dry sterile dressing. Pt is on Cipro bid./ Do you want to see pt in office next week?"

C.J. S[redacted] is a registered nurse employed by Desert Hospital Home Health Care Services which was providing home health care to V[redacted] T. The note was written by a member of respondent's staff and it memorializes a telephone call made by S[redacted] to respondent's office. Below the note, respondent wrote "Yes" and underlined it. He first saw the note either the evening of April 14 (a Friday) or the next day.

Respondent next saw V[redacted]T. on April 18, four days after the report of the wound bursting. He recorded in his chart: "Hematoma spontaneously evacuated. Packed open by nurse. Benign. Healing well." He ordered physical therapy and strengthening to continue and she was placed on half weight bearing on her left side.

The x-ray taken of V[redacted] T.'s right hip on April 18 noted a slight change in the fragmental position of the intertrochanteric fracture and a slight migration of the internal fixation device in the femoral head, which now abutted the articular surface. Progressive healing about the fracture site was noted.

The next visit occurred on May 2, 1995. Respondent noted V[redacted] T. was ambulating with a walker about her house and the wound had healed with full range of motion. She was to continue physical therapy and strengthening and return in four weeks.

The last time respondent saw V[redacted] T. was on May 30. He indicated she reported she had persistent right hip pain and her range of motion was reduced. The x-ray of the right hip indicated progressive migration of the internal fixation pin in the femoral head with stable healing of the comminuted fracture. He reported the serial findings were suggestive of avascular necrosis of the femoral head. Respondent's interpretation of the x-ray report was of degenerative osteoarthritis, osteoporosis and the metal had migrated through the bone. His diagnosis was advanced osteoarthritis right hip with migrating metal. He recommended a right total hip arthroplasty and removal of the metal. He noted he had discussed the proposed procedure with V[redacted] T. and she understood and desired the procedure. He gave her a prescription for darvocet (a controlled substance for pain).

5. Dr. Hugh Nasr was V[redacted] T.'s family doctor while respondent attended to her orthopedic problems. Dr. Nasr addressed some of the patient's other problems. While his treatment of those problems is not relevant to this case, it should be noted that on February 23 and March 1, 1995, he ordered blood tests. The white blood count on February 23 was high which was suggestive of an infection, and the red blood count was low, but the white and red blood counts on March 10 were normal.

Dr. Nicholas Wyskoarko performed a cardiovascular evaluation of V[redacted] T. on May 5, 1995, and found she had congestive heart failure and possible mitral regurgitation with cardiac dysfunction.

Dr. Maria Greenwald saw V[redacted]T. on June 15, 1995 to evaluate her osteoporosis. In her report to Dr. Nasr, Dr. Greenwald noted the patient was in a wheelchair and unable to bear full weight due to right hip pain. Her diagnosis included osteoporosis with many exacerbating factors, including cigarette use, low body weight, and lack of estrogen since 1945, Paget's, and painful right hip.

6. V[redacted]T. went to Dr. Douglas Roger on June 19, 1995 for a second opinion regarding the surgery respondent proposed to her right hip. She complained of severe right hip pain and said she had had pain since the surgery. She told him she had developed an infection and the wound drained in May, she had had serial packing for approximately three to four weeks, and she had taken antibiotics. She reported the wound had healed but she had considerable pain and was unable to bear weight.

Dr. Roger examined V[redacted]T. and found a healed wound on the right side, no open areas, and tenderness to passive range of motion. She was unable to bear weight on the right lower extremity secondary to pain. He also examined the May 30 x-ray.

Dr. Roger explained to V[redacted]T. she had a failed hip screw on the right and he was concerned about it as well as about the possibility of infection. He noted her history of infection about six weeks before although she did not appear to have any infection clinically. He told her it was extremely important if, in considering future reconstruction surgery, to have blood work in the form of CBC, erythrocyte sedimentation rate, serum active protein, and hip joint aspiration under fluoroscopy to see if there is any evidence of infection. He indicated to her if there was no infection, she might be a candidate for a one-stage reconstruction to a bipolar prosthesis, but if there was infection, she would need to have the hardware removed and debridement of the soft tissues and probably the hip joint. She said she wanted to proceed with laboratory and diagnostic evaluation of infection. Dr. Roger indicated they would pursue her future course based on the results of these tests.

7. Within the next few days, V[redacted]T.'s right hip joint was aspirated and was found positive for staphylococcus aureus. With that finding and increasing pain, Dr. Roger admitted her to Desert Hospital for surgery. On June 25, 1995, he performed irrigation, debridement, hardware removal, and a Girdlestone procedure of the infected right hip screw. He placed multiple drains and placed her in intravenous antibiotics. Postoperatively, she developed multiple organ system failure, and she went downhill rapidly. She died on July 10, 1995. An autopsy performed on July 13, 1995, attributed the cause of death to blunt force trauma with bilateral fractured femurs, staphylococcus infection and subsequent hemorrhage into surgical site, with contributing factors including coagulopathy with multiple intracerebral hemorrhages, chronic obstructive lung disease and atherosclerotic cardiovascular disease.

8. The first supplemental accusation charges respondent with repeated negligent acts and incompetence for ignoring evidence of a developing infection of V[redacted]T.'s right hip, failing to perform laboratory work, failing to mention infection when he recommended further surgery on May 30, failing to recognize failure of the metal fixation device, and other reasons.

9. Dr. J. Pierce Conaty testified on behalf of complainant. He reviewed all the relevant medical records and concluded respondent's management and care of V[redacted] T. was below the standard of care and therefore negligent, and also incompetent, beginning on April 11, 1995. By that time according to Dr. Conaty, respondent should have been concerned about the possibility of infection and should have ordered some basic laboratory tests be performed, including taking a temperature, a complete blood count, sedimentation rate, performing an aspiration and/or more sophisticated tests.

Respondent testified in his own behalf, and his testimony was supported by Dr. Kendall Wagner. Dr. Wagner testified respondent's conduct was not incompetent or below the standard of care. Both he and respondent testified they believed what occurred on April 11 and shortly thereafter was a "suture spitout" and was not evidence of infection. A spitout is the body's effort to rid itself of a suture which was supposed to be absorbed. Instead of the suture being absorbed, the body treats it as a foreign body, like a splinter, and when the body rids itself of it, blood and pus and redness may be present. In respondent's view, this represented a superficial infection and there was no reason to suspect a deeper wound infection was present.

While respondent's chart supports his testimony he felt what he observed on April 11 was a superficial wound infection, it does not support his testimony he felt it was a suture spitout. On April 18, he called what was described in the note of April 14 as a hematoma. He did not see it. He never saw the suture spitout either. He only saw some redness. The absence of any documentation that he felt the signs he observed on April 11 and 18, and the information he was provided by the nurse via the note on April 14, was a suture spitout compels the conclusion that was not his thinking at that time.

10. Respondent offered several additional explanations for not investigating the possibility of a deep wound infection. He testified he did not order any blood counts because he felt they would be elevated anyway because V[redacted] T. had recently suffered severe trauma and surgery, she had chronic lung problems, and she experienced recurring urinary tract infections. This is more of an after the fact justification for inaction than an explanation. Dr. Nasr ordered blood tests in February and March, and the one in March showed a normal white count. Thus, respondent's alleged fears the tests would be meaningless or confusing has no basis in fact or reason.

Respondent testified he was concerned about spreading an infection if he aspirated the wound. An aspiration involves inserting a needle into the hip joint and removing fluid which is then tested for the presence of bacteria. He testified if he inserted a needle through a superficial infection, the needle would spread the bacteria into the bone, thereby causing more harm than good. Dr. Wagner agreed with this assessment.

Dr. Conaty did not address this point, but he made it clear an aspiration was not required until the lab tests came back and provided more evidence of infection, such as an elevated white count. Since respondent did not order any tests, it cannot be determined if the risks of performing an aspiration outweighed the benefits. In any event, while respondent might have had a valid concern about the safety of performing an aspiration in general, the fact remains he never considered doing one on V[redacted] T. because he did not believe she had a deep wound infection.

11. Respondent's chart contains little information about V[redacted] T.'s complaints of pain. Respondent testified he expected her to experience discomfort, so if that were her complaint, he did not record it. His practice is to record only milestones; the absence of any record of complaints of pain indicated to respondent she did not complain of it.

Eichert, V[redacted] T's daughter, accompanied her mother to each of her visits to respondent's office. Each time she went to respondent's office, V[redacted] T. complained about pain in her right leg at the incision site. E[redacted] also watched her mother attempt physical therapy; the therapy caused her to experience excruciating pain. Eichert's testimony that V[redacted] T. complained of pain is supported by the histories taken by Drs. Roger and Greenwald in June. In addition, respondent's note of May 30 indicates a complaint that the right hip pain persists. It was established V[redacted] T. experienced pain throughout the post-operative period while respondent treated her and respondent failed to chart that complaint.

12. E[redacted] was present on April 14, 1995, when the wound in V[redacted] T.'s right leg burst open, prompting the call from S[redacted] to respondent's office. E[redacted] observed a large quantity of pus and estimated the amount at two cups. The pus was collected by S[redacted] There was no evidence offered that respondent made any effort to have the pus brought into his office for analysis. E[redacted] and V[redacted] T. told respondent about the incident when V[redacted] T. returned to his office on April 18. At that time, respondent's nurse cleaned and bandaged it.

13. Dr. Conaty is an orthopedic surgeon and has been licensed since 1952. He became board certified in 1960. He maintained a private practice in orthopedics and also taught orthopedics. He recently retired from a position he held since 1991 as a clinical professor in the Department of Orthopedics at UCI. He also taught at USC. His staff appointments included chief of the surgical arthritis service at Rancho Los Amigos Hospital in Downey and Chief of Surgery at St. Jude Hospital, Fullerton. He has served on numerous committees, including quality review committees at St. Jude, UCI, and Rancho Los Amigos. He has written numerous articles in the field of orthopedics. His testimony was quite

persuasive. He was fair towards respondent. He was careful not to criticize him unless the facts warranted it. He gave respondent the benefit of the doubt.

Dr. Wagner has been an orthopedic surgeon for 15 years. After attending USC Medical School, he joined Dr. Conaty's private practice. He did a fellowship at Rancho Los Amigos in adult foot and ankle. He became board certified in 1986. He has been a chairman of the ethics committee of the Orange County Medical Association and in that capacity, has sent cases to the Board and has evaluated cases coming to the association from the Board. Dr. Wagner's testimony at the hearing was not as unbiased as that of Dr. Conaty. There were times when he appeared to be defending respondent. In weighing the qualifications and the demeanor of the two experts who testified in this matter, it must be concluded Dr. Conaty's testimony is entitled to greater weight.

14. According to Dr. Conaty, orthopedists live in constant fear of infection. This case shows why. Based upon Dr. Conaty's testimony, it was established by clear and convincing evidence that respondent's management and care of V[redacted]T. fell below the standard of care when he failed to recognize post operative infection and failed to proceed with the appropriate course of treatment.

On April 11, 1995, respondent noticed redness at the wound site. The history he received from the patient was that it had been there for three days. This was a new finding and occurred three months after the surgery. At this point, an infection is most likely a deep wound infection, not the superficial one respondent thought. Respondent should have acted to establish or rule out the possibility of a deep wound infection by ordering such basic lab tests as a complete blood count, sedimentation rate or temperature, or by ordering more sophisticated tests. These tests should have been done before respondent placed the patient on an antibiotic. If any of the tests suggested the possibility of an infection, further testing such as an aspiration would have become necessary.

Any thought respondent had the infection was a superficial one should have been rejected when he learned of the wound bursting and oozing pus and blood on April 14. That information plus respondent's observations on April 18 should have alerted him to the possibility of a deep wound infection. Mrs. Eichert was present to confirm to respondent on April 18 there was a large quantity of pus on April 14. This was not a hematoma.

The x-ray taken on April 18 revealed a slight change in the fragmental position of the fracture and slight migration of the internal fixation device. Respondent should have been concerned the fracture had not healed, the pin was in a different position, and an infection was slowing down the healing process.

By May 30, the x-ray revealed the pin had shifted significantly. This meant the fracture had not healed and was accompanied by considerable pain, as respondent indicated in his note of May 30. That note also diagnosed the patient as having advanced osteoarthritis right hip with migrating metal. This diagnosis was partially incorrect. Rather, she had an infected non-union of the fracture with migrating metal. The diagnosis is important because it determines the subsequent surgery. If there were no infection, a one-stage reconstruction could be performed. That is what respondent recommended. But if an infection is present, a two step procedure is required, with removal of the hardware and debridement of the joint and soft tissues done first. Thus, before the decision on the type of surgery could be made, a workup has to be done to determine if an infection is present. Respondent failed to consider that possibility in his note of May 30. That failure is below the standard of care.

In summary, respondent's management and care of V[redacted] T. constituted repeated negligent acts when he failed to recognize a post operative deep wound infection, he failed to proceed with an appropriate course of treatment, he incorrectly diagnosed the condition of the hip fracture, and he recommended a form of surgery without knowing if the patient had an infection.

None of the other allegations of negligence charged in paragraph 7 of the first supplemental accusation were established.

15. It was not established respondent's management and care of V[redacted] T. constituted incompetence. Incompetence is a lack of knowledge or ability in performing professional duties, and is generally difficult to establish when only one act or one patient is involved. Respondent made several errors in judgment in this case but the facts do not establish he did not know how to diagnose or treat an infection or handle a patient after a surgical repair of a fracture had failed.

16. Respondent is 53 years old and has been licensed as a physician for 19 years. He graduated cum laude from Yale University in June, 1967 and did a year of graduate study at Oxford University. He attended the University of Iowa Medical School from 1972 to 1976, and did a surgical internship and residency at the Naval Regional Medical Center in San Diego. He became board certified in orthopedic surgery in 1986 and has been in private practice in Palm Springs since 1989. He was chairman of the Department of Orthopedic Surgery and Chairman of the Executive Committee of the medical staff at the U.S. Naval Hospital in San Francisco, and the Chairman of the Department of Orthopedic Surgery at Desert Hospital in Palm Springs.

17. It was established the Board incurred the following costs of investigation and prosecution of this matter: Attorney General costs of $5,575.00; expert reviewer costs of $375.00; and investigator costs of $2,240.00, for a total of $8,190.00. The amount is reasonable.

LEGAL CONCLUSIONS

1. Cause for discipline of respondent's license for violation of Business and Professions Code section 2234(d), incompetence, was not established by reason of Finding 15.

2. Cause for discipline of respondent's license for violation of Business and Professions Code section 2234(c), repeated negligent acts, was established by reason of Findings 4-7 and 9-14.

3. Respondent shall reimburse the Board for its costs of investigation and enforcement under Business and Professions Code section 125.3 in the amount of $8,190.00.

4. Respondent's errors in this case occurred in a very narrow area, the recognition and treatment of infection in a post-operative patient. Based upon his curriculum vitae and his testimony at the hearing, it is evident respondent is a fine, knowledgeable physician. Thus, requiring respondent to take additional educational courses and to participate in a clinical training program focusing on infection is the most effective way to address this problem. Other conditions of probation, such as an oral/clinical exam or SPEX examination, or monitoring, or a prohibition against solo practice, are not necessary. Furthermore, while a five year period of probation is generally imposed in a case such as this, respondent's record as a physician suggests it will be unnecessary for the Board to monitor his activities for that long a period of time.

ORDER

Certificate No. C 38701 issued to respondent Glenn D. Cunningham, M.D. is revoked pursuant to Legal Conclusion 2. However, the revocation is stayed and respondent is placed on probation for three (3) years upon the following terms and conditions:

1. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California, and remain in full compliance with any court ordered criminal probation, payments and other orders.

2. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation.

3. Respondent shall comply with the Division's probation surveillance program. Respondent shall, at all times, keep the Division informed of his addresses of business and residence which shall both serve as addresses of record. Changes of such addresses shall be immediately communicated in writing to the Division. Under no circumstances shall a post office box serve as an address of record.

   Respondent shall also immediately inform the Division, in writing, of any travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) days.

4. Respondent shall appear in person for interviews with the Division, its designee or its designated physician(s) upon request at various intervals and with reasonable notice.

5. In the event respondent should leave California to reside or to practice outside the State or for any reason should respondent stop practicing medicine in California, respondent shall notify the Division or its designee in writing within ten days of the dates of departure and return or the dates of non-practice within California. Non-practice is defined as any period of time exceeding thirty days in which respondent is not engaging in any activities defined in Sections 2051 and 2052 of the Business and Professions Code. All time spent in an intensive training program approved by the Division or its designee shall be considered as time spent in the practice of medicine. Periods of temporary or permanent residence or practice outside California or of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary period.

6. Upon successful completion of probation, respondent's certificate shall be fully restored.

7. If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation or petition to revoke probation is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

8. Respondent shall reimburse the Division the amount of $8,190.00 within 90 days from the effective date of this decision for its investigative and enforcement costs. Failure to reimburse the Division's cost of its investigation and enforcement shall constitute a violation of the probation order, unless the Division agrees in writing to payment by an installment plan because of financial hardship. The filing of bankruptcy by the respondent shall not relieve the respondent of his responsibility to reimburse the Division for its investigative and prosecution costs.

9. Following the effective date of this decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may voluntarily tender his certificate to the Board. The Division reserves the right to evaluate the respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the tendered license, respondent will no longer be subject to the terms and conditions of probation.

10. Respondent shall pay the costs associated with respondent's probation monitoring each and every year of probation. Such costs shall be payable to the Division at the end of each fiscal year. Failure to pay such costs shall be considered a violation of probation.

11. Within 90 days of the effective date of this decision, and on an annual basis thereafter, respondent shall submit to the Division or its designee for its prior approval an educational program or course to be designated by the Division, which shall not be less than 40 hours per year, for each year of probation. At least 30 hours per year of these additional 40 hours shall be in courses related to the diagnosis and treatment of infection. This program shall be in addition to the Continuing Medical Education requirements for re-licensure. Following the completion of each course, the Division or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of continuing medical education of which 40 hours were in satisfaction of this condition and were approved in advance by the Division or its designee.

12. Within 90 days of the effective date of this decision, respondent shall submit to the Division or its designee for prior approval, a clinical training program. The exact number of hours and specific content of the program shall be determined by the Division or its designee. Participation and completion of the PACE program at the UCSD School of Medicine shall be constitute satisfaction of this condition. Respondent shall successfully complete the training program and

may be required to pass an examination administered by the Division or its designee related to the program's contents.

13. Within 15 days of the effective date of this decision, respondent shall provide the Division, or its designee, proof of service that respondent has served a true copy of this decision on the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent or where respondent is employed to practice medicine and on the Chief Executive Officer at every insurance carrier where malpractice insurance coverage is extended to respondent.

Dated: November 19, 1998

ALAN S. METH
Administrative Law Judge
Office of Administrative Hearings

REDACTED

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO November 25 19 97
BY Hattie Johnson ANALYST

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	No. 09-96-65983
GLENN D. CUNNINGHAM, M.D. 375 Via Las Palmas Palm Springs, CA 92262 Physician's and Surgeon's Certificate No. C 38701 Respondent.	**ACCUSATION**

Complainant Ron Joseph, as cause for disciplinary action, alleges:

PARTIES

1. Complainant Ron Joseph is the Executive Director of the Medical Board of California ("Board") and makes and files this accusation solely in his official capacity.

2. On or about June 25, 1979, Physician's and Surgeon's Certificate No. C 38701 was issued by the Board to Glenn D. Cunningham, M.D. ("respondent"), and at all times relevant herein, said Physician's and Surgeon's Certificate was,

and currently is, in full force and effect. Unless renewed, it will expire on January 31, 1999.

JURISDICTION

3. This accusation is made in reference to the following statutes of the California Business and Professions Code ("Code"):

A. Section 2227 provides that the Board may revoke, suspend for a period not to exceed one year, or place on probation and order the payment of probation monitoring costs, the license of any licensee who has been found guilty under the Medical Practice Act.

B. Section 2234 provides that unprofessional conduct includes, but is not limited to, the following:

". . . .

"(c) Repeated negligent acts.

"(d) Incompetence.

". . . ."

C. Section 125.3 provides, in part, that the Board may request the administrative law judge to direct any licentiate found to have committed a violation or violations of the licensing act, to pay the Board a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

4. Section 16.01 of the 1997/1998 Budget Act of the State of California provides, in pertinent part, that: (a) no funds appropriated by this act may be expended to pay any Medi-Cal claim for any service performed by a physician while that

physician's license is under suspension or revocation due to a disciplinary action of the Medical Board of California; and, (b) no funds appropriated by this act may be expended to pay any Medi-Cal claim for any surgical service or other invasive procedure performed on any Medi-Cal beneficiary by a physician if that physician has been placed on probation due to a disciplinary action of the Medical Board of California related to the performance of that specific service or procedure on any patient, except in any case where the board makes a determination during its disciplinary process that there exist compelling circumstances that warrant continued Medi-Cal reimbursement during the probationary period.

FIRST CAUSE FOR DISCIPLINE

(Incompetence)

5. Respondent Glenn D. Cunningham, M.D., is subject to disciplinary action on account of the following:

A. On or about January 17, 1995, V[redacted] T., then 88 years of age, was injured and taken to Desert Hospital. There, she saw respondent, who diagnosed her as having suffered a displaced intertrochanteric fracture of the right hip and a fracture of the distal left femur with displacement. Respondent recommended that V[redacted] T. undergo an operation involving an open reduction and internal fixation (hereafter ORIF) of the right hip and left femur, and the recommendation was accepted by V[redacted] T. and her family.

///

B. On January 18, 1995, respondent operated on Virginia T. and performed an ORIF of her right hip and her distal left femur.

C. Respondent saw V[redacted] T. postoperatively for the first time on March 6, 1995. Respondent noted that the hip had a good range of motion and the x-rays looked good with callus formation.

D. Respondent next saw V[redacted] T. on March 28, 1995. She complained of right hip discomfort. Respondent noted that she had no reddening or swelling, and that x-rays showed a healing fracture. Respondent ordered that V[redacted] T. continue physical therapy.

E. Respondent next saw V[redacted] T. on April 3, 1995. X-rays showed no significant alteration of the fixation device. V[redacted] T. continued non-weight-bearing on her right side, and respondent ordered a walker for her.

F. Respondent saw V[redacted] T. again on April 11, 1995, and noted that she complained of wound erythema (reddening) for the past three days; he noted erythema in an exam that day as well. Respondent felt there was a "possible superficial infection" and ordered cipro for V[redacted] T. Respondent did not perform any aspiration of the wound, nor did he order a culture.

G. On April 14, 1995, a home health care person noted that Virginia T.'s wound "burst this a.m. oozing pus and some blood. Able to get Q-tip down 3.5 cm." The person writing the note queried whether respondent wanted to see

the patient next week, and an appointment is written on the note.

H. On April 18, 1995, respondent saw V[redacted] T. and noted the wound on her right hip, charting, "hematoma spontaneous evacuated, packed open by nurse. Benign. Healing well." Respondent made no note regarding purulence (whether pus was present). X-rays on that date show a slight change in the fragmental position of the intertrochanteric fracture and migration of the internal fixation device cephalad (head of the screw) in the femoral head.

I. Respondent saw V[redacted] T. again on May 2, 1995. He noted that she was walking with assistance of a walker in her house. He found the left hip femur wound healed. There was full range of motion of the hip and the knee was virtually normal.

J. V[redacted] T.'s next visit to respondent was on May 30, 1995, more than four months after the surgery. She again complained of persistent right hip pain. X-rays of the right hip showed degenerative osteoarthritis and osteoporosis. In addition, the metal screw used in the ORIF had migrated through the bone and was protruding past the bone into tissue. The x-rays also showed erosion of the bone, as well as "avascular necrosis of the femoral head."

K. After the examination and x-rays of May 30, respondent recommended a total right hip arthroplasty (total right hip replacement) and removal of the metal. He

discussed the recommendation with V[redacted] T., and she agreed. She received a prescription for Darvocet.

L. V[redacted] T. went to Dr. R. for a second opinion. She told him that she was continuing to have significant pain in her right hip, even after the infection healed. After an examination and review of the May 30 x-rays, Dr. R. concluded that the hip screw on the right had "cut out." Dr. R. told V[redacted] T. that the screw in her right hip had failed and that he was concerned about the screw and about the possibility of infection. He noted that V[redacted] T. had a history of infection and recommended specific blood tests to discover infection as well as aspiration under fluoroscopy to see if there was any evidence of infection in the hip joint fluid. V[redacted] T. agreed to Dr. R.'s plan.

M. V[redacted] R. was again admitted to Desert Hospital on June 25, 1995, to carry out the plan developed by Dr. R. Before admission, she had undergone aspiration of her hip joint and the fluid tested positive for infection, staph aureus. Dr. R. was concerned that the infection had tracked up through the center of the lag screw and up into the hip joint. The night before her admission, V[redacted] T. had called Dr. R. and told him that she was having severe right hip pain and that she was shaking. Dr. R. was concerned that the infection was worsening. He intended to schedule removal of the implant and resection of the hip joint as soon as possible.

N. Dr. R. obtained a series of consults, then operated on V[redacted] T. later that same morning. When he opened the fascia, approximately 300 cc of purulent fluid was obtained, and four sets of cultures taken. Dr. R. removed the screw, which was very loose, removed all infected or necrotic tissue, and cleaned all areas which appeared infected. He performed a Girdleston arthroplasty.

O. After the surgery, V[redacted] T. went downhill fairly quickly and died on July 20, 1995. The causes of death were listed as cardiac arrest due to respiratory failure, shock and acute renal failure. Other conditions which contributed to her death were listed as COPD, congestive heart failure, septic right hip, and ileus.

6. Respondent is subject to disciplinary action for unprofessional conduct in that he was incompetent in his care and treatment of V[redacted] T., in violation of Code section 2234(d). The circumstances are as follows:

A. Paragraph 5 of this Accusation is realleged and incorporated by reference as if set forth in full.

B. Respondent ignored evidence of developing infection in V[redacted] T. in April 1995, including erythema of the wound (on April 11), spontaneous drainage of pus (on April 14), continuous pain during the entire post-surgical course, and the marked failure of the metal fixation device.

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C. Respondent mistakenly referred to the bursting of V[redacted] T.'s wound on April 14, 1995, which oozed pus and some blood, as a "spontaneous evacuation of hematoma."

D. Respondent did not perform aspiration of V[redacted] T.'s wound at any time during his care of her.

E. Respondent did not perform any lab work to determine the presence of an infection, such as CBC, erythrocyte sedimentation rate, and serum active protein.

F. Respondent made no mention of the possibility of infection as late as May 30, 1995, the last time he saw the patient. His diagnosis at that time was "advanced osteoarthritis right hip with migrating metal." However, he stated in an interview on June 17, 1997, that he told the patient and her daughter on that date that if there was persistent infection at the time of the hardware removal that the procedure would have to be staged using antibiotic treatment prior to doing a total hip replacement.

G. Respondent also stated in an interview on June 17, 1997, that V[redacted] T. tolerated ambulation satisfactorily. However, she complained of pain during the entire postoperative course, and was non-weight-bearing for part of that course, and those facts are noted in respondent's records.

H. Respondent failed to visit V[redacted] T. while she was his postoperative patient in a skilled nursing facility.

I. Respondent did not recognize failure of the metal fixation device, a common postoperative complication of the ORIF procedure he had performed.

J. Respondent failed to discover a wound infection in V[redacted] R.'s right hip.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

7. Respondent is subject to disciplinary action for unprofessional conduct in that he committed repeated negligent acts in his care and treatment of V[redacted] T., in violation of Code section 2234(c). The circumstances are set forth in paragraphs 5 and 6A-6J of this Accusation, which are realleged and incorporated by reference as if set forth in full.

PRAYER

WHEREFORE, complainant requests that a hearing be held on the matters alleged herein, and that following said hearing, the Board issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number C 38701, heretofore issued to respondent Glenn D. Cunningham, M.D.;

2. Directing respondent Glenn D. Cunningham, M.D. to pay to the Board a reasonable sum for its investigative and enforcement costs of this action;

3. Ordering respondent to pay the Board the monetary costs associated with the monitoring of probation; and

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4. Taking such other and further action as the Board deems appropriate to protect the public health, safety and welfare.

DATED: November 25, 1997

Ron Joseph
Executive Director
Medical Board of California

Complainant

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REDACTED

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BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **GLENN D. CUNNINGHAM, M.D.** 375 Via Las Palmas Palm Springs, CA 92262 Physician's and Surgeon's Certificate No. C 38701 Respondent.	No. 09-96-65983 **OAH NO.** L-1997120372 **FIRST SUPPLEMENTAL ACCUSATION**

Complainant Ron Joseph, as cause for disciplinary action, alleges:

PARTIES

1. Complainant Ron Joseph is the Executive Director of the Medical Board of California ("Board") and makes and files this accusation solely in his official capacity.

2. On or about June 25, 1979, Physician's and Surgeon's Certificate No. C 38701 was issued by the Board to Glenn D. Cunningham, M.D. ("respondent"), and at all times relevant herein, said Physician's and Surgeon's Certificate was, and currently is, in full force and effect. Unless renewed, it will expire on January 31, 1999.

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JURISDICTION

3. This accusation is made in reference to the following statutes of the California Business and Professions Code ("Code"):

A. Section 2227 provides that the Board may revoke, suspend for a period not to exceed one year, or place on probation and order the payment of probation monitoring costs, the license of any licensee who has been found guilty under the Medical Practice Act.

B. Section 2234 provides that unprofessional conduct includes, but is not limited to, the following:

". . . .

"(c) Repeated negligent acts.

"(d) Incompetence.

". . . ."

C. Section 125.3 provides, in part, that the Board may request the administrative law judge to direct any licentiate found to have committed a violation or violations of the licensing act, to pay the Board a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

4. Section 16.01 of the 1997/1998 Budget Act of the State of California provides, in pertinent part, that: (a) no funds appropriated by this act may be expended to pay any Medi-Cal claim for any service performed by a physician while that physician's license is under suspension or revocation due to a disciplinary action of the Medical Board of California; and, (b) no funds appropriated by this act may be expended to pay any Medi-Cal claim for any surgical service or other invasive procedure performed on any Medi-Cal beneficiary by a physician if that physician has been placed on probation due to a disciplinary action of the Medical Board of California related to the performance of that specific service or procedure on any patient, except in any case where the board makes a determination during its disciplinary

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process that there exist compelling circumstances that warrant continued Medi-Cal reimbursement during the probationary period.

FIRST CAUSE FOR DISCIPLINE

(Incompetence)

5. Respondent Glenn D. Cunningham, M.D., is subject to disciplinary action on account of the following:

A. On or about January 17, 1995, V[redacted] T., then 88 years of age, was injured and taken to Desert Hospital. There, she saw respondent, who diagnosed her as having suffered a displaced intertrochanteric fracture of the right hip and a fracture of the distal left femur with displacement. Respondent recommended that V[redacted] T. undergo an operation involving an open reduction and internal fixation (hereafter ORIF) of the right hip and left femur, and the recommendation was accepted by V[redacted] T. and her family.

B. On January 18, 1995, respondent operated on V[redacted] T. and performed an ORIF of her right hip and her distal left femur.

C. V[redacted] T. was transferred to a skilled nursing facility on January 23, 1995. V[redacted] T. had periods of febrile episodes up to 101.2 degrees in the post-operative period. She was discharged to her home on February 17, 1995, ambulating with a pick-up walker, with complaints of residual hip pain.

D. Respondent saw V[redacted] T. post-operatively for the first time on March 6, 1995. Respondent noted that the hip had a good range of motion and the x-rays looked good with callus formation. Respondent advised physical therapy to strengthen and increase range of motion of the hip. X-rays at that time noted a comminuted intertrochanteric fracture with gross posterior medial proximal displacement of the distal major fragment, estimated at 2.5 cm with a large comminuted greater trochanteric fragment of displaced cephalad (head of screw) and lateral.

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E. Respondent next saw V[redacted] T. on March 28, 1995. She complained of right hip discomfort. Respondent noted that she had no reddening or swelling, and that x-rays showed a healing fracture. Respondent ordered that V[redacted] T. continue physical therapy.

F. Respondent next saw V[redacted] T. on April 3, 1995. X-rays showed no significant alteration of the fixation device. V[redacted] T. continued nonweight-bearing on her right side, and respondent ordered a walker for her.

G. Respondent saw V[redacted] T. again on April 11, 1995, and noted that she complained of wound erythema (reddening) for the past three days; he noted erythema in an exam that day as well. Respondent felt there was a "possible superficial infection" and ordered Cipro (an antibiotic) for V[redacted] T. Respondent did not perform any aspiration of the wound, nor did he order a culture.

H. On April 14, 1995, a home health care person noted that V[redacted] T.'s wound "burst this a.m. oozing pus and some blood. Able to get Q-tip down 3.5 cm." The person writing the note queried whether respondent wanted to see the patient next week, and an appointment is written on the note.

I. On April 18, 1995, respondent saw V[redacted] T. and noted the wound on her right hip, charting, "hematoma spontaneous evacuated, packed open by nurse. Benign. Healing well." Respondent made no note regarding purulence (whether pus was present). X-rays on that date show a slight change in the fragmental position of the intertrochanteric fracture and migration of the internal fixation device cephalad (head of the screw) in the femoral head.

J. Respondent saw V[redacted] T. again on May 2, 1995. He noted that she was walking with assistance of a walker in her house. He found the left hip femur wound healed. There was full range of motion of the hip and the knee was virtually normal.

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K. V[redacted] T.'s next visit to respondent was on May 30, 1995, more than four months after the surgery. She again complained of persistent right hip pain. X-rays of the right hip showed degenerative osteoarthritis and osteoporosis, In addition, the metal screw used in the ORIF had migrated through the bone and was protruding past the bone into tissue. The x-rays also showed erosion of the bone, as well as "avascular necrosis of the femoral head."

L. After the examination and x-rays of May 30, respondent recommended a total right hip arthroplasty (total right hip replacement) and removal of the metal. He discussed the recommendation with V[redacted] T., and she agreed. She received a prescription for Darvocet.

M. On June 19, 1995, V[redacted] T. went to Dr. R. for a second opinion. She told him that she was continuing to have significant pain in her right hip, even after the infection healed. After an examination and review of the May 30 x-rays, Dr. R. concluded that the hip screw on the right had "cut out." Dr. R. told V[redacted] T. that the screw in her right hip had failed and that he was concerned about the screw and about the possibility of infection. He noted that V[redacted] T. had a history of infection and recommended specific blood tests to discover infection as well as aspiration under fluoroscopy to see if there was any evidence of infection in the hip joint fluid. V[redacted] T. agreed to Dr. R.'s plan.

N. V[redacted] T. was again admitted to Desert Hospital on June 25, 1995, to carry out the plan developed by Dr. R. Before admission, she had undergone aspiration of her hip joint and the fluid tested positive for infection, staphylococcus aureus. Dr. R. was concerned that the infection had tracked up through the center of the lag screw and up into the hip joint. The night before her admission, V[redacted] T. had called Dr. R. and told him that she was having severe right hip pain and that she was shaking. Dr. R. was concerned that the infection was worsening. He intended to schedule removal of the implant and resection of the hip joint as soon as possible.

O. On June 25, 1995, Dr. R. obtained a series of consults, then operated on V[redacted] T. later that same morning. When he opened the fascia, approximately 300 cc of purulent fluid was obtained, and four sets of cultures taken. Dr. R. removed the screw, which was very loose, removed all infected or necrotic tissue, and cleaned all areas which appeared infected. He performed a Girdleston arthroplasty.

P. After the surgery, V[redacted] T. developed multiple organ system failure and her medical condition deteriorated fairly quickly. V[redacted] T. died on July 20, 1995. The causes of death were listed as cardiac arrest due to respiratory failure, secondary to shock and associated with renal failure. Other conditions which contributed to her death were listed as COPD, congestive heart failure, septic right hip, and ileus.

6. Respondent is subject to disciplinary action for unprofessional conduct in that he was incompetent in his care and treatment of V[redacted] T., in violation of Code section 2234(d). The circumstances are as follows:

A. Paragraph 5 of this Accusation is realleged and incorporated by reference as if set forth in full.

B. Respondent ignored evidence of developing infection in V[redacted] T. in April 1995, including erythema of the wound (on April 11), spontaneous drainage of pus (on April 14), continuous pain during the entire post-surgical course, and the marked failure of the metal fixation device.

C. Respondent mistakenly referred to the bursting of V[redacted] T.'s wound on April 14, 1995, which oozed pus and some blood, as a "spontaneous evacuation of hematoma."

D. Respondent did not perform aspiration of V[redacted] T.'s wound at any time during his care of her.

E. Respondent did not perform any lab work to determine the presence of an infection, such as CBC, erythrocyte sedimentation rate, and serum active protein.

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F. Respondent made no mention of the possibility of infection as late as May 30, 1995, the last time he saw the patient. His diagnosis at that time was "advanced osteoarthritis right hip with migrating metal." However, he stated in an interview on June 17, 1997, that he told the patient and her daughter on that date that if there was persistent infection at the time of the hardware removal that the procedure would have to be staged using antibiotic treatment prior to doing a total hip replacement.

G. Respondent also stated in an interview on June 17, 1997, that Virginia T. tolerated ambulation satisfactorily. However, she complained of pain during the entire post-operative course, and was nonweight-bearing for part of that course, and those facts are noted in respondent's records.

H. Respondent failed to visit V[redacted] T. while she was his post-operative patient in a skilled nursing facility.

I. Respondent failed to recognize the developing post-operative infection and failed to proceed with the appropriate course of treatment of the infection.

J. Respondent's documentation in the patient records was inadequate to properly identify a common post-operative complication of a hip fracture and a wound infection in an elderly patient.

K. Respondent did not recognize failure of the metal fixation device, a common post-operative complication of the ORIF procedure he had performed.

L. Respondent failed to discover a wound infection in Virginia T.'s right hip.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

7. Respondent is subject to disciplinary action for unprofessional conduct in that he committed repeated negligent acts in his care and treatment of V[redacted] T., in violation of Code section 2234(c). The circumstances are set forth in paragraphs 5 and 6A-6L of this Accusation, which are realleged and incorporated by reference as if set forth in full.

PRAYER

WHEREFORE, complainant requests that a hearing be held on the matters alleged herein, and that following said hearing, the Board issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number C 38701, heretofore issued to respondent Glenn D. Cunningham, M.D.;

2. Directing respondent Glenn D. Cunningham, M.D. to pay to the Board a reasonable sum for its investigative and enforcement costs of this action;

3. Ordering respondent to pay the Board the monetary costs associated with the monitoring of probation; and

4. Taking such other and further action as the Board deems appropriate to protect the public health, safety and welfare.

DATED: 10-6-98

Ron Joseph
Executive Director
Medical Board of California

Complainant

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